Division of Health Care Facilities

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8603	A. BUILDING: 01 - MAIN BUILDING 01 B. WING	R 05/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 848}	1200-8-6-.08 (18) Building Standards (18) It shall be demonstrated through the submission of plans and specifications that in each nursing home a negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces; and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure janitor closets were maintained at a negative air pressure. The findings include: Observation and interview during a follow up survey with the Director of Nursing, on May 20, 2013 at 8:50 a.m. confirmed the west janitors closet exhaust was not working. This finding was verified by the Housekeeping Supervisor and acknowledged by the Administrator during the exit conference on May 20, 2013.	{N 848}	No residents were affected The exhaust in the west janitor's closet was corrected. Maintenance will make 5 random checks of room exhaust monthly to ensure exhaust is working properly. The checks will be monitored in the Quality Assurance Committee meeting on a monthly basis for one year. The Quality Assurance Committee (made up of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Quality Assurance Nurse, and Department Heads) may make changes to the process and will determine when compliance has been met.	Completion Date 6/30/13

Division of Health Care Facilities

Christopher A. Gobble

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 6/5/13